



CLAIM FORM AND INSTRUCTIONS

If you have any questions regarding benefits available, or how to file your claim, or if you would like to appeal any determination, please contact our Customer Care Center at 1-800-348-4489, 8:00 A.M. to 8:00 P.M. Eastern Standard Time

The furnishing of this form, or its acceptance by the Company as proof, must not be construed as an admission of any liability on the part of the Company, nor a waiver of any of the conditions of the insurance contract.

INSTRUCTIONS FOR FILING YOUR GROUP ACCIDENT CLAIM

• Please check the box or boxes that best describes your current claim:

- | | | |
|--|--|---|
| <input type="checkbox"/> Dismemberment | <input type="checkbox"/> Ambulance Services: | <input type="checkbox"/> Accidental Death* |
| <input type="checkbox"/> Dislocation/Fracture | <input type="checkbox"/> Ground Ambulance | <input type="checkbox"/> Common Carrier Accidental Death* |
| <input type="checkbox"/> Initial Hospitalization Confinement | <input type="checkbox"/> Air Ambulance | |
| <input type="checkbox"/> Medical Expenses | | |

* Should someone covered under this policy suffer an accidental death, please call 1-904-992-2556 so that we may provide special assistance.

• Providing the documentation requested below will ensure that your claim can be processed for benefit. The following is the documentation that is **required** for **ACCIDENT CLAIM**:

A copy of the itemized billing statement and a radiology report if filing for the fracture benefit.

• Include your policy number(s). To obtain your policy number call 1-800-348-4489. Please be assured that your claim will receive our prompt attention.

• You may **fax** your claim to us at 1-866-424-8482. Please be assured that your claim will receive our prompt attention.

• You may mail your claim to: **American Heritage Life Insurance Company**
P.O. Box 43067
Jacksonville, Florida 32203-3067

• Additional claim forms are available on our website at www.allstateatwork.com.

• If you are filing a claim within the first 12 months your policy is in force, additional information may be required.

POLICYHOLDER / CERTIFICATEHOLDER

Employer Name (Company/Address): _____ Occupation: _____

1. Policyholder's Name: First: _____ Middle: _____ Last: _____

Policy Number(s): 1) _____ 2) _____

Social Security Number: _____ Date of Birth: ____ / ____ / ____ Male Female

2. Home Number: (____) _____ E-mail: _____

PATIENT'S INFORMATION

3. Name: First: _____ Middle: _____ Last: _____

4. Date of Birth: ____ / ____ / ____ Age: _____ Social Security Number: _____ Male Female

5. This person is your: _____ (ex: self, wife, son, etc.) Is he/she a full-time student? Yes No
If yes, please submit proof of student status.

GROUP ACCIDENT POLICY CLAIMS

DATE OF ACCIDENT: ____ / ____ / ____ Time of accident: _____ a.m. p.m.

Where did it happen? _____ Tell us exactly how your accident/injury happened: _____

